

SUMMARY OF BENEFITS

Connecticut General Life Insurance Co.



City of Houston Cigna Limited Network Plan Powered by Cigna

| PAPAnnual deductibles and maximums | In-network |
|--|---|
| Lifetime maximum | Unlimited per individual |
| Pre-Existing Condition Limitation (PCL) | Not applicable |
| Plan Year plan deductible | \$0 Employee \$0 Employee and Family |
| Plan Year out-of-pocket maximum <ul style="list-style-type: none"> Expenses that count towards your out-of-pocket maximum include inpatient facility, outpatient facility and advanced radiological imaging copays. Other copays do not count towards the out-of-pocket maximum. <p><u>Family Maximum Calculation:</u> The Family Maximum is met when copays, as described above, for all covered family members reach \$3,000 except that no single family member shall meet more than \$1,500.</p> | \$1,500 Individual \$3,000 Individual and Family |

| Benefits | In-network |
|---|--|
| Physician services | |
| Office visit copay <ul style="list-style-type: none"> Specialist copay applies to OB/GYN physician | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| Surgery performed in a physician's office | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| Preventive care | |
| <ul style="list-style-type: none"> Routine preventive care for children Immunizations Well-woman and well-man exam | No charge |
| Mammogram, PSA, PAP Smear, Colonoscopy and Maternity Screening <ul style="list-style-type: none"> Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services) | No charge No charge |

| Benefits | In-network |
|---|--|
| Inpatient hospital facility services | |
| Semi-private room and board and other non-physician services <ul style="list-style-type: none"> Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. Private room stays may result in extra charges for the patient. | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| Inpatient Hospital Physician's Visits/Consultations/Services to include but not limited to surgeons, radiologists, pathologists and anesthesiologists | No charge |
| Multiple surgical reduction <ul style="list-style-type: none"> Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. | Not applicable |
| Outpatient services | |
| Outpatient surgery (facility charges) <ul style="list-style-type: none"> Non-surgical treatment procedures are not subject to the facility copay Outpatient surgery performed in a Free-Standing Surgical Facility and same-day inpatient surgery performed in a Hospital without an overnight stay (including invasive diagnostic procedures such as cardiac catheterization). | \$300 copay per visit, (\$600 maximum per participant per plan year) then plan pays 100% |
| Outpatient Professional Services delivered as part of Outpatient Surgery – Facility Services noted above including but not limited to surgeons, radiologists, pathologists and anesthesiologists | Plan pays 100% |
| Physical, occupational, cognitive and speech therapy <ul style="list-style-type: none"> Unlimited for all therapies combined per plan Year Includes cardiac rehabilitation, physical therapy, speech therapy, occupational therapy, chiropractic therapy (includes chiropractors), pulmonary rehabilitation and cognitive therapy Outpatient Short Term Rehab copay applies, regardless of place of service, including the home | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| Lab and X-ray | |
| Lab and X-ray <ul style="list-style-type: none"> Physician's office | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> Outpatient hospital facility | No charge No charge for outpatient professional services |
| <ul style="list-style-type: none"> Independent lab facility Independent x-ray and/or lab facility as part of an ER visit | No charge |

| Benefits | In-network |
|--|--|
| Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. <ul style="list-style-type: none"> Inpatient facility | Covered under Inpatient Hospital – Facility Services |
| <ul style="list-style-type: none"> Outpatient facility | You pay a per scan copay of \$100 |
| <ul style="list-style-type: none"> Physician's office Emergency room | You pay a per scan copay of \$100 |
| Emergency and urgent care services | |
| Hospital emergency room <ul style="list-style-type: none"> Including radiology, pathology and physician charges Copay waived if admitted | No charge after \$200 per visit copay |
| Ambulance | No charge after \$100 per day copay |
| Urgent care services <ul style="list-style-type: none"> Copay waived if admitted | No charge after \$60 per visit copay |
| Other health care facilities | |
| Skilled nursing facility, rehabilitation hospital and other facilities <ul style="list-style-type: none"> 60 days combined | No charge |
| Home health care <ul style="list-style-type: none"> 60 days per plan year (Includes outpatient private nursing when approved as medically necessary) | No charge |
| Hospice <ul style="list-style-type: none"> Inpatient services Outpatient services (same coinsurance level as Home Health Care) Bereavement Counseling (Inpatient & Outpatient Services) | No charge |
| Other health care services | |
| Durable medical equipment <ul style="list-style-type: none"> Unlimited per plan year maximum Wigs will be covered for post-chemotherapy patients to a maximum of \$300. Hearing Aids (Subject to a \$1,000 max every 36 months) Limitations may apply | No charge |
| External prosthetic appliances (EPA) <ul style="list-style-type: none"> Unlimited maximum per plan year | No charge |
| Nutritional Evaluation – Plan Year <i>3 visits per person</i> <ul style="list-style-type: none"> Physician's Office | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |

| Benefits | In-network |
|---|--|
| <ul style="list-style-type: none"> Inpatient Facility | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| <ul style="list-style-type: none"> Outpatient Facility | \$300 copay per visit, (\$600 maximum per participant per plan year) then plan pays 100% |
| TMJ <ul style="list-style-type: none"> Physician's office | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> Inpatient facility | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| <ul style="list-style-type: none"> Outpatient facility | \$300 copay per visit, (\$600 maximum per participant per plan year) then plan pays 100% |
| <ul style="list-style-type: none"> Physician's services | No Charge |
| Maternity care services Employee, all dependants <ul style="list-style-type: none"> Initial visit to confirm pregnancy (OB/GYN provider is a Specialist) | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> All subsequent prenatal visits, postnatal visits and physician's delivery charges | No charge |
| <ul style="list-style-type: none"> Physician's Office visits in addition to the global maternity fee when performed by an OB/GYN or Specialist | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> Delivery – Facility | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| Infertility Treatment <ul style="list-style-type: none"> Office visit for testing, treatment and artificial insemination Surgical treatment limited to procedures to correct infertility | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> Office Visit | |
| <ul style="list-style-type: none"> Inpatient Facility | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |

| Benefits | In-network |
|---|--|
| Outpatient Facility | \$300 copay per visit, (\$600 maximum per participant per plan year) then plan pays 100% |
| Family planning Includes contraceptive devices <ul style="list-style-type: none"> Office visits | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| Surgical services such as tubal ligation or vasectomy are covered (Excluding reversals). <ul style="list-style-type: none"> Physician's Office | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> Inpatient Facility | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| <ul style="list-style-type: none"> Outpatient Facility | \$300 copay per visit, (\$600 maximum per participant per plan year) then plan pays 100% |
| Abortion Covers non-elective procedures only <ul style="list-style-type: none"> Physician's Office Visit | Primary Care Physician You pay \$30 per visit Specialist You pay \$60 per visit |
| <ul style="list-style-type: none"> Inpatient Facility | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| <ul style="list-style-type: none"> Outpatient Facility | \$300 copay per visit, (\$600 maximum per participant per plan year) then plan pays 100% |
| Mental health and substance abuse services | |
| Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: <ul style="list-style-type: none"> Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 60-day time period. | |
| Inpatient mental health services <ul style="list-style-type: none"> Unlimited days per plan year Mental health services are paid at 100% after you reach your out-of-pocket maximum. | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |

| Benefits | In-network |
|---|--|
| Outpatient mental health physician's office services <ul style="list-style-type: none"> Unlimited visits per plan year This includes individual, group therapy mental health and intensive outpatient mental health Weekly limitations may apply | \$30 per visit copay |
| Outpatient mental health facility services <ul style="list-style-type: none"> Unlimited visits per plan year Non-surgical treatment procedures are not subject to the facility copayment This includes individual, group therapy mental health and intensive outpatient mental health Weekly limitations may apply | \$30 per visit copay |
| Inpatient substance abuse services <ul style="list-style-type: none"> Unlimited days per plan year Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. | \$500 copay per day, (\$1,000 maximum per participant per plan year) then plan pays 100% |
| Outpatient substance abuse physician's office services <ul style="list-style-type: none"> Unlimited visits per plan year This includes intensive outpatient substance abuse services. Weekly limitations may apply | \$30 per visit copay |
| Outpatient substance abuse facility services <ul style="list-style-type: none"> Unlimited visits per plan year Non-surgical treatment procedures are not subject to the facility copayment This includes intensive outpatient substance abuse services. Weekly limitations may apply | \$30 per visit copay |

| Benefits | In-network | |
|---|---|----------------|
| Prescription Drugs | | |
| Pharmacy coverage | In-Network | Out-of-Network |
| Cigna Pharmacy four-tier copay plan <ul style="list-style-type: none">• Generic• Self administered injectables – excludes infertility drugs• Includes Oral Contraceptives | Retail (30 day supply) You pay: Generic \$10 Preferred brand \$45 Non-preferred brand \$60 4 th Tier/Specialty Not Available at Retail Pharmacies Home Delivery (90 day supply) You pay: Generic \$25 Preferred brand \$113 Non-preferred brand \$150 4 th Tier/Specialty \$100 Limited to 30 day supply | Not Covered |
| Pharmacy year plan deductible <ul style="list-style-type: none">• Applies to in-network and out-of-network | \$100 Individual \$300 Individual and Family | |
| Specialty Pharmacy <ul style="list-style-type: none">• Clinical Programs<ul style="list-style-type: none">◦ Prior authorization required on specialty medications and quantity limits may apply.◦ TheraCare® Program• Medication Access Option: Home Delivery Only | | |
| Cigna Vision – through Cigna Vision Network Providers <ul style="list-style-type: none">• Annual (Plan Year) Exam• Materials (frames and lenses) | No charge Not covered, but minimum 20% savings on purchase of frames and/or lenses with valid prescription are available through Cigna Vision Network Savings Program. Discount does not apply to Contact Lenses, however 15% discount on fit/evaluation for Contact Lenses is available through Cigna Vision eye care professionals. Check with your Cigna Vision Network eye care professionals for details. | |

Definitions

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Direct Access to Obstetricians and Gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Selection of a Primary Care Provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Cigna Home Delivery Pharmacy – You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's not covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Obesity surgery and services
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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